

EXHIBIT “G”

Name: DASRATH, ANAND EMMANUEL Enter your USMLE/ECFMG identification number if one has been assigned to you: 0-7024-7022-7
 Last, First, Middle (as indicated in item 4)

PART C — MEDICAL EDUCATION AND EMPLOYMENT INFORMATION

25. CERTIFICATION BY APPLICANT: Students and graduates must sign this application in the presence of their Medical School Dean, Vice Dean or Registrar. (See 25.2.A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public. (See 25.2.B below.)
 Application forms are to be mailed to ECFMG from the office of the official or notary who attests the applicant's signature. All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.

I hereby certify that I currently meet the examination eligibility requirements and that the information in this application is true, and accurate to the best of my knowledge and that the photograph(s) enclosed were taken within 6 months of the date of this application. I also certify and acknowledge that I have read the 2006 ECFMG Information Booklet and 2006 USMLE Bulletin of Information, am aware of the contents of both publications, meet the eligibility requirements set forth and agree to abide by the policies and procedures therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or rescind the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See page 35 of the 2006 Information Booklet for additional details concerning Violation of Standards and Integrity Behavior.)

I understand that the Standard ECFMG Certificate and any and all topics thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I request and authorize every person, medical school, university, hospital, government agency, or other entity to release information, records, diplomas, transcripts and other documents concerning my professional education, attendance status or enrollment to ECFMG upon request of ECFMG.

I hereby authorize ECFMG to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information. For further information regarding ECFMG's data collection and privacy practices, please refer to our privacy policy available on the ECFMG website at www.ecfm.org/privacy.html.

Signature of Applicant (in Latin characters) X Anand Emmanuel Dasrath
 (Signature must match full legal name as given in PART A-1)



Seal or stamp of official must cover a part of attached photo and a part of application form.
 Certifying official must also complete Item 25.2.A or 25.2.B below.

12 03 2006
 Day Month Year

25.2 CERTIFICATION BY OFFICIAL:

25.2.A CERTIFICATION BY MEDICAL SCHOOL OFFICIAL (Must be completed for medical school students):

I hereby certify that the photograph, signature, and information entered in all parts of Section 23 of this form, including medical school attendance dates, and status of medical school student (if applicable) accurately apply to the individual named above, and that this individual is (must check one):

☒ officially enrolled in or ☐ a graduate of the institution indicated below. I have affixed the medical school seal or stamp over a portion of the photograph above.

Signature of Medical School Official (in Latin characters) X Bryette Gena

20 03 2006
 Day Month Year

Bryette Gena
 Print Name (in Latin characters)

ASSOCIATE REGISTRAR OF CLINICAL SCIENCES ROSS UNIVERSITY

Official Title (with English translation, if not in English) Institution SCHOOL OF MEDICINE

OR

25.2.B CERTIFICATION BY OFFICIAL IDENTIFICATION (Pertains to graduates only):

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify the individual as (must check one):
 (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the identifying document, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.
 The statements in this document are subscribed and sworn to before me by the applicant

on this _____ day, of the month of _____, in the year _____

MAY - 5 2006

X Signature of Consular Official, First Class Magistrate, or Notary Public (in Latin characters) Title (with English translation, if not in English) ECFMG
MINIMUM 2

27. CLINICAL CLERKSHIPS — Continue on a separate sheet of paper, if necessary:

Clinical Discipline	Hospital/Clinic	Location (exact address)	Supervising Physician	Dates of Clerkship

PART D — OTHER EXAM HISTORY AND APPLICANT NUMBERS

28. OTHER EXAM HISTORY and APPLICANT NUMBERS:

Check below the organizations (other than ECFMG) to which you previously applied for examinations. Enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.

<input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS	Applicant Identification Number: <u> </u>	USMLE Steps 1/2	Date of Most Recent Examination Taken: <u> </u>
	Applicant Identification Number: <u> </u>	USMLE Parts 1/II	Date of Most Recent Examination Taken: <u> </u>
<input type="checkbox"/> STATE LICENSING AUTHORITY IN THE UNITED STATES	FIN - Federation Identification Number: <u> </u>	FLEX	Date of Most Recent Examination Taken: <u> </u>

